

Sources of funding: The study was supported by a grant from the Medical Research Council with funds from the Department of Health, the Scottish Executive, and the National Assembly for Wales.

Conflict of interest: None declared.

Accepted for publication 11 July 2002

References

- 1 Lavreys L, Rakwar JP, Thompson ML, *et al.* Effect of circumcision on human immunodeficiency virus type 1 and other sexually transmitted diseases: a prospective cohort study of trucking company employees in Kenya. *J Infect Dis* 1999;180:330–6.
- 2 Cook LS, Koutsky LA, Holmes KH. Circumcision and sexually transmitted diseases. *Am J Public Health* 1994;84:197–201.
- 3 Weiss HA, Quigley MA, Hayes RJ. Male circumcision and risk of HIV infection in sub-Saharan Africa: a systematic review and meta-analysis. *AIDS* 2000;14:2361–70.
- 4 Johnson AM, Mercer CH, Erens B, *et al.* Sexual behaviour in Britain: partnerships, practices, and HIV risk behaviours. *Lancet* 2001;358:1835–42.
- 5 National Statistics. 2001 Census: First results on population for England & Wales. London: Office for National Statistics, 2002.
- 6 Laumann EO, Masi CM, Zuckerman EW. Circumcision in the United States. Prevalence, prophylactic effects, and sexual practice. *JAMA* 1997;277:1052–7.

Cutaneous larva migrans of the penis

Cutaneous larva migrans (CLM) is a distinctive cutaneous eruption caused by the invasion and migration of larva of parasites in skin.¹ It is also known by various other



Figure 1 A linear serpentine lesion seen extending from the tip of the prepuce on to the shaft.

names, such as creeping eruption, sand worm, plumber's itch, duck hunter's itch, and epidermatitis linearis migrans.² CLM occurs commonly in exposed areas, such as feet, buttocks, and hand.¹ Isolated occurrence of CLM on the penis is very rare and, hence, rarely reported.

A 24 year old unmarried male agricultural labourer presented with itchy lesions on the penis of 5 days' duration. The lesion started on the tip of the prepuce and gradually progressed upwards in a serpentine fashion. He had no lesions elsewhere on the body. He denied a history of premarital sexual contact but had visited a beach resort. He had not applied any topical medication on his penis.

On physical examination, the patient was uncircumcised. A linear serpentine lesion was seen extending from the tip of the prepuce to the shaft on the ventral aspect of the penis (fig 1). He had no other skin lesions.

His routine haemogram and serum biochemistry were within normal limits. Stool examination did not reveal any parasites. A clinical diagnosis of cutaneous larva migrans was made and he was put on oral albendazole 400 mg twice daily for 3 days. The lesion stopped progressing after 2 days of treatment. The lesion completely subsided by 7 days and there was no recurrence at follow up after 4 weeks.

Cutaneous larva migrans is a self limiting dermatitis commonly known as "creeping eruption,"² because of its distinctive feature that the lesion creeps or migrates caused by the presence of a moving parasite in the skin. CLM has a worldwide distribution though it is common in the tropics and subtropics.² The occurrence of CLM is influenced by poor sanitation and appropriate environmental conditions.³

The clinical features of CLM may vary from non-specific dermatitis to typical creeping eruption. The initial lesion starts as an erythematous itchy papule. Soon, a slightly raised flesh coloured swollen lesion about 2–3 mm thick develops and forms linear, serpentine (serpiginous), or bizarre tracts. The larva migrates about 2–5 cm per day and forms the tortuous tracts.⁴ Sometimes, multiple vesicles may appear along the tract. Rarely, hundreds of tracts may be seen in a severely infected person.⁵

Cutaneous larva migrans can be grouped into several types depending upon the species responsible for the lesions and their clinical appearance.⁶ They are type 1 (caused by animal hookworms), type 2 (human hookworms), type 3 (human strongyloides), type 4 (animal strongyloides), type 5 (*Gnathostoma*), and type 6 (insect larva).⁶ CLM is usually caused by third stage larva (filariform larva) of dog and cat hookworms (*Ancylostoma caninum* and *Ancylostoma brasiliensis*, respectively) and rarely by *Uncinaria stenocephala*, *Bunostomum phlebotomum*, or the human larvae of *Necator americanus* and *Ancylostoma duodenale*.^{4,5}

Cutaneous larva migrans is usually self limiting but the symptoms (itching) and possible complications warrant treatment.¹ Various physical treatments, such as surgery and cryotherapy, have been tried with little success. The topical treatments that have

been used include 15% thiabendazole, 2% Gammexane cream, 25% piperazine citrate, and metrifonate.⁷ Though many types of treatment have been used, albendazole is considered to be the drug of choice.⁸ Albendazole is used in the dosage of 400–800 mg/day for a period that may vary from 1–7 days.⁹ Eradication of larva causing CLM is impractical, but avoiding contact with contaminated soil of beaches can prevent it.^{1,2}

In our patient the localisation of CLM was unique and this could possibly be attributed to the habit of not wearing underwear when playing on the beach, thus predisposing him to develop lesions on genitalia.

K Karthikeyan, D M Thappa, B Jeevankumar
Dermatology and STD Department, JIPMER,
Pondicherry - 605006, India

Correspondence to: Professor D M Thappa,
Dermatology and STD Department, JIPMER,
Pondicherry - 605006, India; dmthappa@jipmer.edu

Accepted for publication 25 July 2003

References

- 1 Karthikeyan K, Thappa DM. Cutaneous larva migrans. *Indian J Dermatol Venereol Leprol* 2002;68:252–8.
- 2 Neafie RC, Meyers WM. Cutaneous larva migrans. In: Strickland GT, eds. *Hunter's tropical medicine and emerging infectious diseases*. 8th ed. Philadelphia: Saunders, 2000:797–9.
- 3 Gilman RH. Intestinal nematodes that migrate through skin and lungs. In: Strickland GT, eds. *Hunter's tropical medicine and emerging infectious diseases*. 8th ed. Philadelphia: Saunders, 2000:730–5.
- 4 Bryceon ADM, Hay RI. Parasitic worms and protozoa. In: Champion RH, Burton JL, Burns DA, *et al.*, eds. *Rook/Wilkinson/Ebling textbook of dermatology*. 6th ed. Vol 2. Oxford: Blackwell Science, 1999:971–2.
- 5 Karthikeyan K, Thappa DM. Disseminated cutaneous larva migrans. *Indian J Dermatol* 2002;47:249–50.
- 6 Gutierrez Y. *Diagnostic pathology of parasitic infections with clinical correlations*. 2nd ed. New York: Oxford University Press, 2000:343–53.
- 7 Canizares O. *Clinical tropical dermatology*. Boston: Blackwell Scientific, 1975:210–11.
- 8 Jones SK, Reynolds NJ, Oliwiecki S, *et al.* Oral albendazole for the treatment of cutaneous larva migrans. *Br J Dermatol* 1990;122:99–101.
- 9 Rizzitelli G, Scarabelli G, Veraldi S. Albendazole: a new therapeutic regimen in cutaneous larva migrans. *Int J Dermatol* 1997;36:700–3.

NOTICE

8th European Society of Contraception Congress

The 8th European Society of Contraception Congress will be held from 23–26 June 2004 in Edinburgh, Scotland, UK. For further details please contact ESC Central Office, c/o Orga-Med Congress Office, Essenestraat 77, B-1740 Ternat, Belgium (tel: +32 2 582 08 52; fax: +32 2 582 55 15; email: orgamed.ann@pandora.be; and website: <http://www.contraception-esc.com/edinburg.htm>).